HCAi
Department of Health Care Access and Information

OHCA Investment and Payment Workgroup

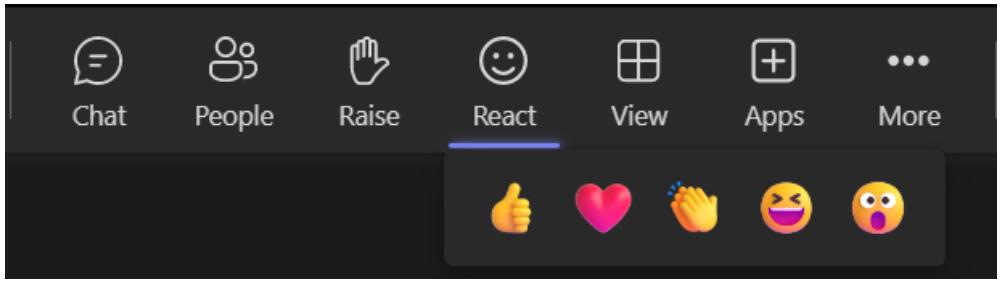
November 21, 2024

Agenda

9:00 a.m.	**1.**	**Welcome, Updates, and Introductions**
9:05 a.m.	**2.**	**What We've Heard From Stakeholders**
9:15 a.m.	**3.**	**Proposed Behavioral Health Investment Benchmark Framework**
10:25 a.m.	**4.**	**Next Steps**
10:30 a.m.	**5.**	**Adjournment**

Meeting Format

- Workgroup purpose and scope can be found in the Investment and Payment Workgroup Charter
- Remote participation via Teams Webinar only
- Meeting recurs the third Wednesday of every month
- We will be using reaction emojis, breakout rooms, and chat functions:



Date: November 21, 2024

Time: 9:00 am PST

Microsoft Teams Link
for Public Participation:
Join the meeting now

Meeting ID: 289 509 010 938
Passcode: r5gbsW

Or call in (audio only):
+1 916-535-0978

Conference ID:
456 443 670 #

Investment and Payment Workgroup Members

Providers & Provider Organizations

Bill Barcellona, Esq., MHA
Executive Vice President of Government Affairs, America's Physician Groups

Lisa Folberg, MPP
Chief Executive Officer, California Academy of Family Physicians (CAFP)

Paula Jamison, MAA
Senior Vice President for Population Health, AltaMed

Amy Nguyen Howell MD, MBA, FAAFP
Chief of the Office for Provider Advancement (OPA), Optum

Parnika Prashasti Saxena, MD
Chair, Government Affairs Committee, California State Association of Psychiatrists

Catrina Reyes, Esq.
Deputy General Counsel, California Primary Care Association (CPCA)

Janice Rocco
Chief of Staff, California Medical Association

Hospitals & Health Systems

Ash Amarnath, MD, MS-SHCD
Chief Health Officer, California Health Care Safety Net Institute

Kirsten Barlow, MSW
Vice President Policy, California Hospital Association (CHA)

Jodi Nerell, LCSW
Director of Local Mental Heath Engagement, Sutter Health

Health Plans

Stephanie Berry, MA
Government Relations Director, Elevance Health (Anthem)

Rhonda Chabran, LCSW
Vice President, Behavioral Health & Wellness, Kaiser Foundation Health Plan, Southern CA & HI

Keenan Freeman, MBA
Chief Financial Officer, Inland Empire Health Plan (IEHP)

Nicole Stelter, PhD, LMFT
Director of Behavioral Health, Commercial Lines of Business, Blue Shield of California

Yagnesh Vadgama, BCBA
Vice President of Clinical Care Services, Autism, Magellan

Consumer Reps & Advocates

Beth Capell, PhD
Contract Lobbyist, Health Access California

Jessica Cruz, MPA
Executive Director, National Alliance on Mental Illness (NAMI) CA

Nina Graham
Transplant Recipient and Cancer Survivor, Patients for Primary Care

Héctor Hernández-Delgado, Esq.
Senior Attorney, National Health Law Program

Cary Sanders, MPP
Senior Policy Director, California Pan-Ethnic Health Network (CPEHN)

Academics/ SMEs

Sarah Arnquist, MPH
Principal Consultant, SJA Health Solutions

Crystal Eubanks, MS-MHSc
Vice President Care Transformation, California Quality Collaborative (CQC)

Kevin Grumbach, MD
Professor of Family and Community Medicine, UC San Francisco

Reshma Gupta, MD, MSHPM
Chief of Population Health and Accountable Care, UC Davis

Vicky Mays, PhD
Professor, UCLA, Dept. of Psychology and Center for Health Policy Research

Catherine Teare, MPP
Associate Director, Advancing People-Centered Care, California Health Care Foundation (CHCF)

State & Private Purchasers

Lisa Albers, MD
Assistant Chief, Clinical Policy & Programs Division, CalPERS

Teresa Castillo
Chief, Program Policy Section, Medical Behavioral Health Division, Department of Health Care Services

Jeffrey Norris, MD
Value-Based Care Payment Branch Chief, California Department of Health Care Services (DHCS)

Monica Soni, MD
Chief Medical Officer, Covered California

Dan Southard
Chief Deputy Director, Department of Managed Health Care

What We've Heard From Stakeholders

Debbie Lindes, Health Care Delivery System Group Manager

What We've Heard from Stakeholders

Theme	Feedback
Goals	• Prevention is important – not all is through the health care system • More behavioral health spend, such as through institutional care, does not necessarily mean better outcomes • Access to care is critical with focus on therapy, peer support, wrap around services, etc. • Affordability should be a goal for measuring and benchmarking ○ Especially addressing out-of-plan spending
Process	• Suggestion to engage additional stakeholders, such as: clinical professional organization representatives, behavioral health providers not in managerial roles, emergency medical services personnel, and people with lived experiences

What We've Heard from Stakeholders

Theme	Feedback

Measurement	• Be clear on goals for measurement and balance with data submitter burden, data quality, and consideration of alternative means for answering policy questions
	• Measure substance use disorders and mental health conditions separately
	• Measurement should include all care settings
	• Questions on how to incorporate diagnosis codes into measurement approach
	• Issues regarding the Behavioral Health in Primary Care module
	  ○ How to define?
	  ○ Concern about availability of primary care clinicians with training in behavioral health care
	  ○ Care management and care team infrastructure may be inadequate to support need
	• Important to capture behavioral health spend via telehealth, spend under global and professional capitation arrangements, and spend by carve-out plans
	• Understand data availability for Employee Assistance Programs
	• Some high-volume services could distort spending measurement

What We've Heard from Stakeholders

Theme	Feedback

Benchmark	• Do not separate mental health and substance use in defining a benchmark, even if data collection makes it possible to measure and report them separately
	• Strong interest in a benchmark that:
	  ○ Prioritizes access to the most appropriate care setting
	  ○ Focuses on certain care settings
	  ○ Reflects evidence-based, high quality behavioral health care
	  ○ Focuses on outpatient/community-based behavioral health care
	• Mixed interest in a benchmark that:
	  ○ Focuses on certain diagnoses or categories of diagnoses
	  ○ Focuses on certain populations or providers

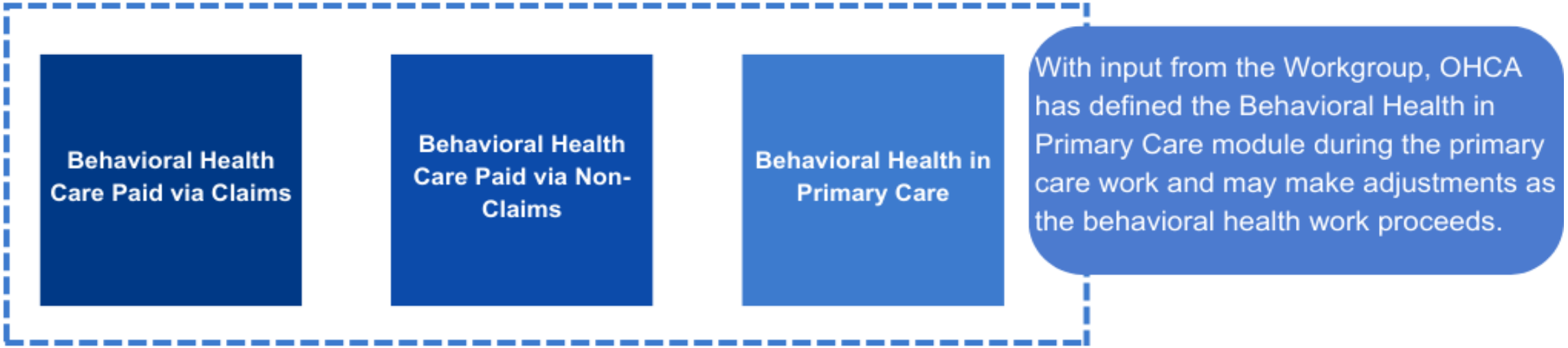
HCAi
Department of Health Care Access and Information

Proposed Behavioral Health Investment Benchmark Framework

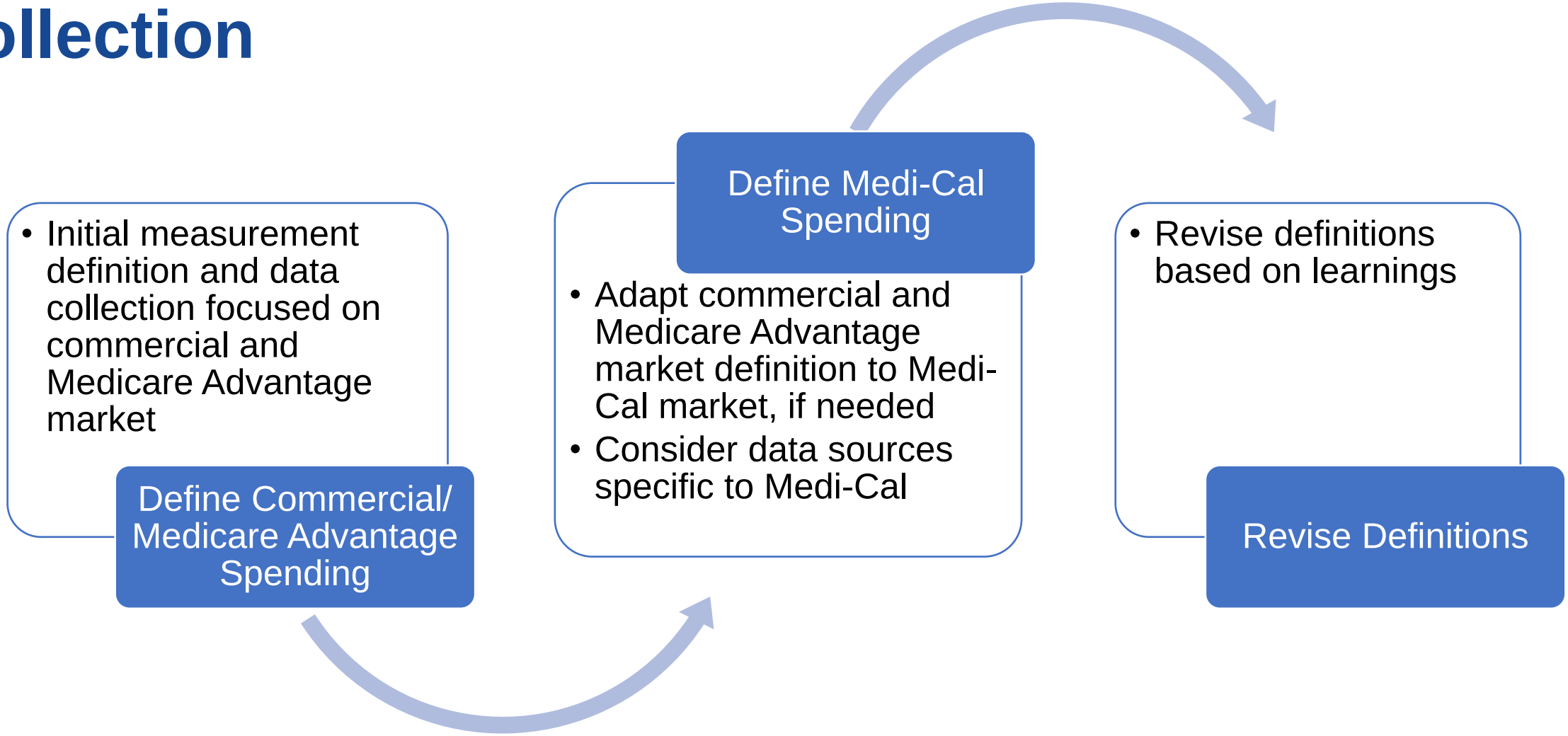
Debbie Lindes, Health Care Delivery System Group Manager
Mary Jo Condon, Principal Consultant, Freedman HealthCare

Three Recommended Modules for Behavioral Health Spending Measurement

OHCA proposes to use three modules to measure behavioral health spending, following the approach for measuring primary care spending. Behavioral health in primary care will be measured separately so it can be included in analyses of behavioral health or primary care spending.



Proposed Phased Approach to Behavioral Health Spending Measurement Definition and Data Collection

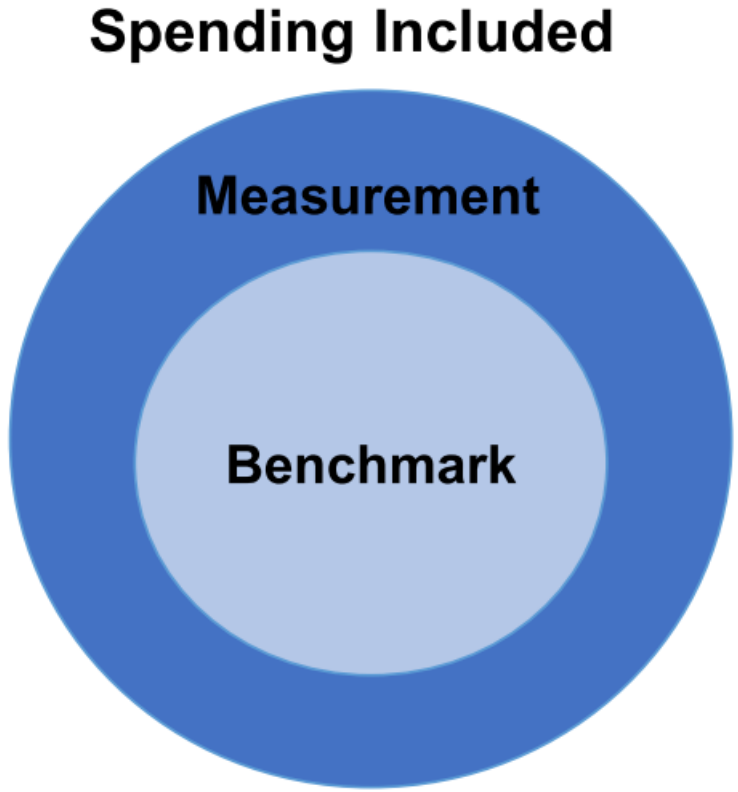


Broad Measurement, Focused Benchmark

- **Measurement:** OHCA will be measuring total behavioral health spending as a percentage of total health care expenditures.

- **Benchmark**: OHCA proposes that the behavioral health investment benchmark applies to a subset of behavioral health care spend.

Today's discussion will focus on a straw model proposal for the behavioral health investment benchmark and will inform later conversations on measurement.



Today's Discussion

Informed by stakeholder input to date, OHCA has developed a straw model framework for the behavioral investment benchmark.

We would like to test this framework with you and discuss a few related questions.

1. What should the increased behavioral health investment achieve?
2. How should OHCA structure the benchmark to achieve this aim?
3. How should the benchmark be focused?
4. What supplemental analyses could support monitoring whether the aim is achieved?

1. What should the increased behavioral health investment achieve?

OHCA Draft Proposal:
Increased investment should help individuals in need of behavioral health care to receive more timely care, in more appropriate settings, and with less out-of-pocket spending via improved access to in-network, outpatient and community-based services.

2. How should OHCA structure the benchmark to achieve this aim?

Proposed Approach to Benchmark	Rationale
Applies to in-network, outpatient/community-based behavioral health services covered via commercial and Medicare Advantage* plans, excluding pharmaceutical spend	• Focuses new investment on high-value, “upstream” care delivery and services that OHCA wants to incentivize • Addresses lack of in-network access to providers and resulting consumer cost burden

*OHCA would initially focus on commercial and Medicare Advantage and expand to Medi-Cal when data collection and methodology allow.

3. How should the benchmark be focused?

OHCA Draft Proposal:

For in-network, outpatient/community-based behavioral health services:

- Include mental health and substance use disorders and define broadly.
- Include specific high-value behavioral health services with limited access and the highest potential to improve outcomes.
- Include spending for all behavioral health services received by California commercial and Medicare Advantage* members, regardless of age or geography.

*OHCA would initially focus on commercial and Medicare Advantage and expand to Medi-Cal when data collection and methodology allow.

4. What supplemental analyses could support monitoring whether the aim is achieved?

Potential Analyses*:

- Proportion of behavioral health services that occur in outpatient/community-based setting
- Emergency department use for behavioral health needs
- Monitoring access to inpatient behavioral health services
- Average therapy sessions per member
- Rates of behavioral health screening
- Spending specifically for integrated behavioral health care
- Quality measures related to behavioral health care and follow-up
- Number and distribution of providers billing for behavioral health services
- Licensed providers in payer networks as a percentage of total licensed providers in California

*OHCA will evaluate the feasibility of these potential analyses.

Example: Rhode Island Behavioral Health Investment Benchmark

The Rhode Island Office of the Health Insurance Commissioner (OHIC)'s **behavioral health spending obligation** focuses on community-based behavioral health care for commercial fully-insured children and adolescents, ages 0-18.

Spending obligation (benchmark):

- In 2025, carriers must increase per member, per month spending on community-based behavioral health care for target population to 200% of baseline (defined as calendar year 2022 spending)
- After 2025, carriers must have annual expenditures on community-based behavioral health care for the target population at the market average as determined by OHIC
- Includes claims and non-claims spending for community-based behavioral health care
- Applies to spending for residents of Rhode Island who receive care from providers located in Rhode Island
- If carriers do not reach the benchmark, they will be subject to penalties as determined by the Commissioner

Rhode Island Behavioral Health Investment Benchmark

Below are examples of community-based services Rhode Island includes in its spending obligation. It measures spending on a broader set of services.

Are there services on this list you would recommend including or excluding?

Examples:

- Adult community clinical services
- Applied behavioral analysis (ABA)
- Clubhouse Model transition services
- Collaborative care management (i.e., managing behavioral health conditions in primary care)
- Community Behavioral Health Centers (including mobile crisis intervention and community crisis stabilization)
- Early intervention
- Electroconvulsive therapy (ECT) and transcranial magnetic stimulation (TMS)
- Intensive outpatient treatment
- Stand-alone case management
- Outpatient substance use and mental health clinics and outreach, including:
  - Clinical stabilization services
  - Detoxification services
  - Opioid treatment centers (i.e., medication-assisted treatment [MAT])
  - Transitional support services
- Partial hospitalization
- Peer services
- Program for assertive community treatment
- Psychiatric day programs
- Psychotherapy and family/group therapy
- Recovery learning communities
- Respite

State of Rhode Island Office of the Health Insurance Commissioner. Rhode Island Behavioral Health Spend Obligation Implementation Manual, July 2024. https://ohic.ri.gov/sites/g/files/xkgbur736/files/2024-07/RI%20BH%20Implementation%20Manual_CY22%20-%20CY23_2024%207-9.pdf

HCAi
Department of Health Care Access and Information

Next Steps

Margareta Brandt, Assistant Deputy Director

Tentative Timeline for Behavioral Health Work

Between meetings, OHCA will revise draft behavioral health definitions and investment benchmarks based on feedback.

	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
Workgroup	X	X	X	X	X	X	X	X	X	X	X
Advisory Committee				X			X		X		
Board					X		X	X		X	✓

X Provide Feedback ✓ Board Approval

December Workgroup Meeting Preview

Tentative Agenda

- Review and discuss OHCA's preliminary draft recommendations for an approach for measuring claims-based behavioral health care spend.

HCAi
Department of Health Care Access and Information

Adjournment

HCAi
Department of Health Care Access and Information

Appendix

Primary Care & Behavioral Health Investments

Statutory Requirements

- **Measure and promote a sustained systemwide investment in** primary care and **behavioral health.**
- **Measure the percentage of total health care expenditures allocated to** primary care and **behavioral health and set spending benchmarks**.
- Include an analysis of primary care and behavioral health spending and growth, and relevant quality and equity performance measures, in the annual report.
- Consult with state departments, external organizations promoting investment in primary care and behavioral health, and other entities and individuals with expertise in primary care, behavioral health, and health equity.
- Benchmarks and public reporting shall consider differences among payers and fully integrated delivery systems, including plan or network design or line of business, the diversity of settings and facilities through which primary care can be delivered, including clinical and nonclinical settings, the use of both claims-based and non-claims-based payments, and the risk mix associated with the covered lives or patient population for which they are primarily responsible.

Primary Care & Behavioral Health Investments

Statutory Requirements

Promote improved outcomes for behavioral health, including, but not limited to, health care entities making investments in, or adopting models that do, any or all of the following:

a. Integrate primary care and behavioral health services, including screenings for behavioral health conditions in primary care settings or delivery of behavioral health support.
b. Implement innovative approaches that integrate primary care and behavioral health with broader social and public health services.
c. Leverage APMs that provide resources at the practice level to enable improved access and team-based approaches for care coordination, patient engagement, quality, and population health.
d. Deliver higher value behavioral health services with an aim toward reducing disparities.
e. Leverage telehealth and other solutions to expand access to behavioral health, care coordination, and care management.

OHCA's Role in Improving Behavioral Health Outcomes

Systemwide Behavioral Health Goals

Behavioral health care that is:

- Accessible
- Comprehensive
- Coordinated
- Equitable
- High Quality

Motivate

California Stakeholder Actions

- Identify and support higher value care
- Build and sustain infrastructure and capacity
- Promote behavioral health integration with primary care and social and public health services
- Reduce disparities

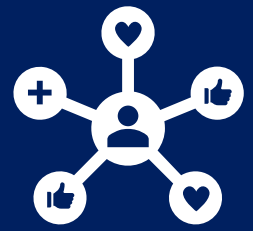
Resulting In

Supports

OHCA's Behavioral Health Workstream

- Promote sustained systemwide investment in behavioral health
- **Measure and report** the percentage of total health care expenditures allocated to behavioral health care
- Set focused **spending benchmarks** to support improved behavioral health outcomes
- Conduct analysis

Proposed Goals for Improved Behavioral Health Care

				
Accessible	**Comprehensive**	**Coordinated**	**Equitable**	**High Quality**
• Providers and services are available when and where needed • Culturally responsive and linguistically concordant • Affordable	• Services across the continuum • More treatment in community and ambulatory settings, reduced need in emergency departments and correctional facilities	• Services integrated across behavioral health settings and with primary care • Attentive and responsive to health-related social needs	• Reduced disparities in utilization and outcomes • Reduced misinformation, stigma, and discrimination	• Improved behavioral health and overall health outcomes • Low frustration, high satisfaction

Adapted from CalHHS, "Policy Brief: Understanding California's Recent Behavioral Health Reform Efforts." March 2023. https://www.chhs.ca.gov/wp-content/uploads/2023/03/CalHHS-Behavioral-Health-Roadmap-_-ADA-03.02.23.pdf